

**STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF DEVELOPMENTAL DISABILITIES (DDD)**

**APPLICATION FOR SERVICE PROVIDERS
NON DDD CONTRACTED AGENCIES**

BACKGROUND INFORMATION

1. Date _____ Information Completed by _____
2. Name of Agency _____ Federal ID/Social Security #: _____
 - a. Agency Address _____
 - b. Billing Address _____
 - c. Agency Web Link Yes ___ No ___ Web Address _____
3. Is your agency a subsidiary of a parent or larger organization? Yes ___ No ___
 - a. If yes, name of parent or larger organization _____
 - b. Address _____
 - c. Telephone # _____ Ext. _____

If your agency will render services out of more than one site location, list each site and its corresponding billing address if different than the address indicated above on page 6 of this application.

4. Agency Type: (check all that apply)
National ___ State ___ Local ___ For Profit ___
Not For Profit ___ Religious Not for Profit ___ Limited Liability Corp. ___
 - a. Executive Director Name _____ Telephone # _____ Ext. _____
 - b. Contact Person Name _____ Telephone # _____ Ext. _____
 - c. Fax # _____ E-Mail Address _____
 - d. Agency Years of Operation _____ Number of Consumers Served Annually _____
 - e. Current Services and Supports Offered: _____

f. Counties Served: Statewide: Yes___ No___ If no, check all of the counties where your agency provides services.

Atlantic___	Bergen___	Burlington___
Camden___	Cape May___	Cumberland___
Essex___	Gloucester___	Hudson___
Hunterdon___	Mercer___	Middlesex___
Monmouth___	Morris___	Ocean___
Passaic___	Salem___	Somerset___
Sussex___	Union___	Warren___

g. **Service Locations: (check all that apply)**

___Consumer's Home ___Community Location ___Agency Site

5. What types of services does your agency wish to qualify to provide to Self Directed Services participants?

___Individual Supports ___Respite ___Camp ___Hotel Respite ___Habilitation
___Supported Employment ___Employment Specialist ___Transportation
___Individual/Group Specialized Instruction

STANDARDS

6. Is your agency a Medicaid provider? ___YES ___NO If yes, please answer the following questions:

- Is your agency in good standing with this provider? ___ YES ___ NO
If no, why? _____
- What is your Medicaid provider contract #? _____
- Who is your Medicaid provider contact person? _____
- Telephone # of provider contact person _____

7. Is your agency a Medicare provider? ___YES ___NO If yes, please answer the following questions:

- Is your agency in good standing with this provider? ___ YES ___ NO
If no, why? _____
- What is your Medicare provider contract #? _____
- Who is your Medicare provider contact person? _____
- Telephone # of provider contact person _____

8. Is your agency a Division of Vocational Rehabilitation Services (DVRS) provider? ___YES ___NO If yes, please answer the following questions:

- Is your agency in good standing with this provider? ___ YES ___ NO
If no, why? _____
- What is your DVRS provider contract #? _____
- Who is your DVRS provider contact person? _____
- Telephone # of provider contact person _____

9. Is your agency a Division of Youth and Family Services (DYFS) provider? ___ YES ___ NO If yes, please answer the following questions:

- a. Is your agency in good standing with this provider? ____ YES ____ NO
If no, why? _____
- b. What is your DYFS provider contract #? _____
- c. Who is your DYFS provider contact person? _____
- d. Telephone # of provider contact person _____

10. Is your agency a Division of Mental Health Services (DMHS) provider? ___ YES ___ NO If yes, please answer the following questions:

- a. Is your agency in good standing with this provider? ____ YES ____ NO
If no, why? _____
- b. What is your DMHS provider contract #? _____
- c. Who is your DMHS provider contact person? _____
- d. Telephone # of provider contact person _____

11. Is your agency a contracted provider for any other state or county agencies? ___ YES ___ NO If yes, please answer the following questions:

- a. Is your agency in good standing with these providers? ____ YES ____ NO
If no, why? _____
- b. Please provide agency name(s), contract #'s and contact person and contact person's telephone number.
Agency Name _____ Contract# _____ Contact Person _____
Telephone Number _____

Agency Name _____ Contract# _____ Contact Person _____
Telephone Number _____

12. Is your agency a contracted provider for any non-state or non-county agencies? ___ YES ___ NO If yes, please answer the following questions:

- a. Is your agency in good standing with these providers? ____ YES ____ NO
If no, why? _____
- b. Please provide agency name(s), contract #'s, agency contact person and contact person's telephone number.
Agency Name _____ Contract# _____ Contact Person _____
Telephone Number _____

Agency Name _____ Contract# _____ Contact Person _____
Telephone Number _____

Agency Name _____ Contract# _____ Contact Person _____
Telephone Number _____

If you answered NO to questions 6 – 12, you must provide two professional letters of

support/recommendation.

13. Are your agency programs required to have a license, certification, accreditation or approval by an outside agency? If yes, complete the following:

Type of Program	Requirement	Term	Issued By

(Copies of licenses, certifications, accreditations or approval letters must be submitted to DDD as part of this application)

a. Are the above indicated licenses, certifications, accreditations or approval currently valid? YES NO If no, why? _____

14. If your agency is not regulated by any outside entity, and/or if your agency has never provided this type of service, and/or if your agency has never provided this type of service to the identified target population(s), what qualifies you to provide this service(s)? Please include a Service Delivery Plan explaining how services are going to be administered and the qualifications of your staff including education, experience, training, and any pertinent certifications.

15. Liability/Malpractice Insurance: Yes No

Name of insurance company _____

Policy # _____

(Proof of insurance coverage must be submitted to DDD as part of this application)

16. Date of Last Fiscal Audit _____

a. Results: Unqualified Qualified

Reason for Qualified Results _____

b. Timely Submittal of Federal and State Returns Yes No

If no, reason for not submitting _____

17. Type of Criminal Background Checks Conducted?

State Local Federal None

18. What type of experience does your agency have supporting individuals with developmental disabilities? _____

of Years _____

19. Two Professional References:

1. Name _____ Title _____
Address _____
City _____ State _____ Zip Code _____
Telephone # _____

2. Name _____ Title _____
Address _____
City _____ State _____ Zip Code _____
Telephone # _____

20. Does your agency wish to provide transportation services? ___ Yes ___ No

If yes, please answer the following questions:

- a. Do all your vehicles have a current New Jersey registration? ___ Yes ___ No
- b. Do all your vehicles have a current New Jersey inspection sticker? ___ Yes ___ No
- c. Are all your vehicles covered by a current auto insurance policy? ___ Yes ___ No
- d. Do all your drivers have a current New Jersey license? ___ Yes ___ No
- e. If applicable, do your drivers have a current New Jersey CDL license? ___ Yes ___ No (If yes, copy of CDL license is required)
- f. Do all your drivers have a driver history abstract completed within the last year? ___ Yes ___ No
- g. Are all your drivers covered by your auto insurance policy? ___ Yes ___ No

Insurance company name _____
Policy # _____

(Proof of vehicle insurance coverage must be submitted to DDD as part of this application)

21. If you are an out of state applicant, please submit the following:

- a. Business plan that outlines how services are to be administered in New Jersey.
- b. New Jersey must be identified as insured on Liability Insurance Certificate.
- c. All licensed professionals providing services must be dually licensed in New Jersey.

I certify that all of the information provided in this application is valid and accurate.

Executive Director Signature

Date

